USING THE PHARMACISTS’ PATIENT CARE PROCESS TO MANAGE HIGH BLOOD PRESSURE AND DIABETES

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About Me

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Objectives

■ Summarize the role of a pharmacist in chronic disease prevention and management.

■ Describe the impact of medication adherence/non-adherence on chronic disease management.

■ Apply the five steps of the Pharmacists’ Patient Care Process to chronic disease patient care.
The Growing Burden of Chronic Disease

Chronic diseases are the leading cause of death and disability in the U.S., and account for 7 out of every 10 deaths.

45% of the U.S. population has at least one chronic disease.

The Number of People with Chronic Conditions is Rapidly Increasing

Number of People with Chronic Conditions (millions)

- 118 (1995)
- 125 (2000)
- 133 (2005)
- 141 (2010)
- 149 (2015)
- 157 (2020)
- 164 (2025)
- 171 (2030)

Percent of People with Chronic Conditions

- 44.7%
- 45.4%
- 46.2%
- 47.0%
- 47.7%
- 48.3%
- 48.8%
- 49.2%

Year

- 1995
- 2000
- 2005
- 2010
- 2015
- 2020
- 2025
- 2030

The Cost of Chronic Disease

In 2010, the U.S. spent $2,236,000,000,000,000 on healthcare costs for people with one or more chronic diseases.

Percent of Healthcare Spending on Patients with One or More Chronic Diseases, 2010

- **All Healthcare Spending**: 86%
- **Medicaid Spending**: 83%
- **Medicare Spending**: 99%

Total U.S. Healthcare Spending by Number of Chronic Conditions in 2010

- No Chronic Conditions: 14%
- 1 Chronic Condition: 15%
- 2 Chronic Conditions: 13%
- 3 Chronic Conditions: 12%
- 4 Chronic Conditions: 11%
- 5+ Chronic Conditions: 35%

The Impact of Chronic Disease

45.1% of people with multiple chronic conditions have activity limitations.

This includes limitations on:
- Bathing
- Toileting
- Dressing
- Eating
- Walking or Moving Around
- Preparing Meals
- Housework
- Shopping
- Taking Medications
- Using Transportation
- Sensory Perception
A Transformation in Healthcare

Infectious Disease
- Acute Care Model
- Fee-for-Service Payment
- Medication Dispensing

Chronic Disease
- Chronic Care Model
- Fee-for-Outcome Payment
- Collaborative Care
- Patient-Centered Medical Home
- Medication Therapy Management
- Pharmacists’ Patient Care Process
WHY INVOLVE PHARMACISTS IN CHRONIC DISEASE MANAGEMENT?
Primary and Secondary Prevention

- Prevent Disease
  - Immunization
  - Disease Screening
  - Tobacco Cessation Assistance
  - Preventive Health Education

- Reduce Impact of Disease
  - Medication Therapy Management
  - Disease Self-Management Education
  - Follow-up Care
Average Annual Visits to Clinician and Number of Prescriptions Filled, by Number of Chronic Conditions (CC), 2010

Medications are one of the foundations of chronic disease management.

91% of all filled prescriptions are for patients with chronic conditions.

Diabetes Medication Adherence and Total Diabetes Healthcare Costs

Diabetes Medication Adherence and the Risk of Hospitalization

THE PHARMACISTS’ PATIENT CARE PROCESS (PPCP)
What is the PPCP?

- A **uniform, consistent** patient care process for pharmacists
- Developed by the Joint Commission of Pharmacy Practitioners in May, 2014
- Gives patients **routine expectations** for patient care services at pharmacy

Step 1: COLLECT

Collect the **key information** necessary for services the pharmacist is being asked to perform.

- Collect **subjective** and **objective** information about the patient
- **Current medication list and medication use history**
- **Relevant health data**
  - *Medical history*
  - *Health and wellness information*
  - *Biometric test results*
  - *Physical assessment findings*
- **Patient lifestyle habits, preferences and beliefs, health and functional goals, and socioeconomic factors**

**For Each Medication:**
- Indication
- Generic and Trade Name
- Dose
- Route of Administration
- Special Instructions
- Date medication was started
- Prescribing Provider
- Refill Date

**Additional Content:**
- Allergies
- Source of current list
- Date of current list
- Providers and contact info
- Medication History

Step 2: ASSESS

Analyze information collected from step 1 and identify and prioritize patient problems.

■ Assess each medication for **appropriateness, effectiveness, safety, and patient adherence**

■ Health and functional status, risk factors, health data, cultural factors, health literacy, and access to medications or other aspects of care

■ Immunization status and the need for preventive care and other health care services, where appropriate

  – Preventive care needs are determined based on medical history, family history, laboratory values, current disease states, and environmental factors

Step 3: PLAN

Development of an **individualized patient-centered care plan** in collaboration with other health care professionals, the patient, and the patient’s caregiver.

Care plan should be **evidence-based**, and **cost-effective**.

- Address medication-related problems and optimize medication therapy
- Set goals of therapy for achieving clinical outcomes in the context of the patient’s overall health care goals and access to care
- Engage the patient through education, empowerment, and self-management
- Support care continuity, including follow-up and transitions of care as appropriate
In collaboration with other health care professionals, and patient or caregiver, implement the care plan.

- Address medication- and health-related problems and engage in preventive care strategies
- Initiate, modify, discontinue, or administer medication therapy as authorized
- Provide education and self-management training
- Contribute to coordination of care, including referral or transition of the patient to another health care professional
- Schedule follow-up care as needed to achieve goals of therapy

SBAR steps
- Situation
- Background
- Assessment
- Recommendation

SOAP Note steps
- Subjective
- Objective
- Assessment
- Plan

Monitor and evaluate the effectiveness of the care plan, and modify the plan in collaboration with other healthcare professionals and patient or caregiver as needed.

- Review medication effectiveness, and safety and patient adherence through available health data, biometric test results, and patient feedback
- Evaluate clinical endpoints that contribute to the patient’s overall health
- Assess outcomes of care, including progress toward the achievement of goals of therapy

### Clinical Measures
- Blood pressure
- HbA1C
- Medication problem resolution
- Adverse drug events
- Adherence

### Humanistic Measures
- Patient medication knowledge
- Patient functioning
- Self-management capability
- Satisfaction

### Economic Measures
- Hospitalizations
- Emergency department visits
- Medication costs

PPCP: A Transformation in Pharmaceutical Healthcare

Traditional Model of Care

Pharmacist Patient Care Process Model
Assessing Capacity for Implementation of the PPCP

Evaluate Existing Services  Develop Quality Improvement Strategies  Implement the PPCP

Benefits of Integrating Pharmacists into the Patient’s Health Care Team

Control of Chronic Conditions
Healthcare Outcomes

Fragmentation of Care
Healthcare Costs
Risk of Hospitalization

A Collaborative Practice Agreement (CPA) is a written and signed voluntary agreement that creates a formal practice relationship between a pharmacist and a prescriber.
The Steps towards Implementing a CPA

Collaborative Practice Agreements are built on a relationship of trust between Pharmacist and Prescriber.

Pharmacist dispenses prescriber’s prescriptions.
Pharmacist and prescriber ask questions and exchange information.
Pharmacist makes recommendations; prescriber strongly considers and often accepts recommendations.
Prescriber delegates responsibilities under a collaborative practice agreement.

PPCP IN WYOMING
Survey of Wyoming Pharmacies

In a 2019 online survey of Wyoming pharmacies, 68.5% of survey respondents (n=54) indicated they did not implement any strategies for applying the Pharmacists’ Patient Care Process to existing patient care services.
Pharmacy Actions to Support Medication Adherence

- Educate on the importance of following prescribed medication regimen
- Educate on dosage/frequency/side-effect/contraindication
- Prescription synchronization
- Automated patient refill reminders
- Specifically monitor refill records to observe if patient is adhering to medication regimen over time
- Provide feedback to primary care physician regarding patient medication adherence/non-adherence

Percent of Respondents Implementing Strategy

- Hypertension
- Diabetes
- Cholesterol
### Pharmacy Actions to Support Lifestyle Behavior Change and Education

<table>
<thead>
<tr>
<th>Action</th>
<th>Percent of Respondents Implementing Strategy</th>
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<tbody>
<tr>
<td>Provide general nutrition information</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Provide general physical activity information</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Screen patients for disease</td>
<td>Cholesterol</td>
</tr>
<tr>
<td>Make referrals to community education programs</td>
<td></td>
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<tr>
<td>Refer patients who use tobacco to the Wyoming Tobacco Quitline</td>
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- Hypertension
- Diabetes
- Cholesterol
Follow up with patients on individual care plans for disease management

Recommend home monitoring with supervision and report back to provider

Work with patients to develop individual care plans for disease management

Offer pharmacy monitoring with supervision and report back to provider

Percent of Respondents Implementing Strategy

Pharmacy Actions to Support Patient Self-Management of Disease

- Hypertension
- Diabetes
- Cholesterol
RESOURCES
Resource Book

How to Implement the Pharmacists’ Patient Care Process

Available for purchase from APhA, Amazon, and other textbook vendors.
Using the Pharmacists’ Patient Care Process to Manage High Blood Pressure: A Resource Guide for Pharmacists
Resource Guide

Collaborative Practice Agreements and Pharmacists’ Patient Care Services
QUESTIONS?

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